No. 4 July, 1916 Vol. IX

Bulletin
OF THE
Ontario Hospitals for the Insane

A Journal Devoted to the interests of Psychiatry in Ontario

Printed by Order of the Legislative Assembly

FOR THE DEPARTMENT OF THE PROVINCIAL SECRETARY.

Printed by A. T. WILGRESS, Printer to the King's Most Excellent Majesty.

Every medical practitioner in Ontario is invited to interest himself in the success of the Hospital for the Insane in the district in which he resides. Every Superintendent realizes that the successful results aimed at in the modern treatment of the insane can be more readily secured by enlisting the co-operation and sympathetic support of the medical men who were formerly the physicians to the patients in their homes. The family Physician naturally watches with interest the course of the hospital treatment and should consider himself an honorary member of the visiting staff of the hospital to which his patients are sent for treatment.

PROCEDURE TO SECURE ADMISSION OF PATIENTS.

The Provincial Secretary desires that all cases that are likely to be benefited by treatment in a Hospital for the Insane should be admitted with the least possible delay.

(1) Where the property of a patient is sufficient, or his friends are willing to pay the cost of the Medical Examination, the family Physician should apply directly to the Medical Superintendent of the Hospital for the Insane, in whose district the patient resides, for the necessary blank forms. These being secured, they should be properly and fully filled in, dated, signed in presence of two witnesses by the medical men in attendance. They are then returned to the Hospital, and if satisfactory, and there is accommodation, advice will be sent at once to have the patient transferred.

(2) Where the patient has no property, and no friends willing to pay the cost, application should be made to the head of the Municipality where he lives, who, after satisfying himself that the patient is destitute, may order the examination to be made by two physicians, and a similar course to the above is then followed. The Council of the Municipality is liable for all costs incurred, including expenses of travel.

(3) Where the patient is suspected to be dangerously insane, information should be laid before a magistrate, who may issue a warrant for the apprehension of the patient and if satisfied that he is dangerously insane, may commit the patient to the custody of someone who will care for him, but not to a lock-up, gaol, prison or reformatory, and notify the Medical Examiners. The Magistrate should then send to the Inspector of Prisons and Public Charities, Parliament Buildings, Toronto, all the information, evidence and certificates of insanity. The costs incurred by this method form a charge against the County, City or Town in which such patient resided.

Voluntary Admission.

The Superintendent of a Hospital for Insane may receive and detain as a patient any person suitable for care and treatment who voluntarily makes written application on a prescribed form, and whose mental condition is such as to render him competent to make application.

A person so received shall not be detained more than five days after having given notice in writing of his desire to leave the hospital.

Convalescent Cottage, Hospital for Insane, Whitby.

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The Bulletin

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Editorial Notes

THE ONTARIO MILITARY HOSPITAL, COBOURG.

THE Hospital for the Insane at Cobourg has been converted into a Military Hospital, to be known as the Ontario Military Hospital, Cobourg. Extensive alterations have been made in the interior of the building in order to provide proper facilities for the treatment of mental and shock cases. On the ground floor two bathrooms, each equipped with two continuous flowing baths, have been added, and adjoining each bathroom is the massage-room, equipped with marble massage slab, shampoo faucets, etc.

In the basement four treatment rooms have been provided. One room is set apart for electric treatment and is equipped with a high-frequency machine and a treatment wall-board. In another room are continuous flowing baths and an electric-hydric bath, together with apparatus for the application of faradic, galvanic and sinusoidal currents. A third room is equipped with a controlling table of marble arranged with mixing chambers with the necessary hot and cold water supply valves for the control of the Scotch douche, needle sprays, waves, showers, etc. In this room are also located electric light and hot air baths, as well as marble massage slab.

Another room is set apart as a dressing and rest room, and is equipped with the necessary beds, blanket warmers, etc.

Dr. F. S. Vrooman, Assistant Superintendent at the Brockville Hospital for the Insane, has been appointed Medical Superintendent, and Dr. H. A. MacKay, Resident Physician at the Ontario Reformatory, Guelph, and formerly of the Toronto Hospital for Insane, has been appointed Assistant.

Miss Gibson, Matron of the Brockville Hospital for Insane, has been appointed Superintendent of Nurses, and all nurses are graduates of the Ontario Training School for Nurses.

THE WHITBY HOSPITAL FOR THE INSANE.

THE first transfer of patients to the new Hospital for Insane at Whitby was effected on the 11th July, when sixty patients were moved from the Hospital for Insane, Cobourg. Since that date one hundred and sixty patients in all have been transferred. Three cottages have been set apart for their use and another cottage is being used for a Nurse's Home. The new dining-room and kitchen have also been opened.

The cottages and other buildings possess many unique features which place the new hospital in the forefront of hospital design and construction. The wards are extremely bright and cheerful, and are so arranged that while all restraint has been eliminated, supervision by the nurses is rendered almost perfect. Each cottage is a hospital in itself, having its own facilities for hydro-therapeutic work and its own diet kitchen. Every room in each building has sanitary coves at the floor line, as well as rounded corners, thereby making impossible any accumulation of dirt.

All wards and single rooms, together with the two side day rooms and upstair corridors, are covered with battleship linoleum. The lower corridors, stairs and main sit-

SITTING-ROOM, HOSPITAL FOR INSANE, WHITBY.

ting-room floors are covered with red quarry tile, manufactured at the Clay Plant of the Provincial Secretary's Department.

Special attention has been paid to clothes-rooms, store-rooms, linen-rooms, etc., and all wooden shelving has been eliminated. Shelving is provided by the use of pipe stands on castors with metal shelves. By this arrangement absolute cleanliness is assured.

There are so many features in connection with this new Hospital that a special Bulletin devoted to it will be published at a later date. It can be safely said that when this Hospital is completed, the Province of Ontario will not only possess the most modern institution of this kind, but will lead in the hospitalization of institutions for the insane.

ORPINGTON HOSPITAL.

Lieut.-Col. Ryan and the other medical officers who, with the twenty graduates of the Training Schools for Nurses of the Ontario Provincial Hospitals for the Insane, form the staff of the Psychiatric section of the Orpington M. Hp., are now busily engaged in their duties at Orpington Hospital. Convoys of soldiers are reaching the Hospital direct from the battle-front in France and Flanders at frequent intervals. Letters received from our representatives there are deeply interesting and show that all are working hard for the recovery of the brave men who have sacrificed so much in the Great Cause.

WAR PSYCHIATRY.

At a meeting of the Royal Medical Academy of Genoa Arturo Morselli, consulting neurologist to the First Army of Italy, presented a communication on war psychiatry which he called a new chapter in mental pathology. He excluded from his purview all the common forms of psychosis which the circumstances of warfare had forced from a condition of latency into active development, and those such as alcoholism, epilepsy and dementia praecox, which had already existed when the patients were mobilized. Dealing only with mental aberrations due directly to the war, he said these mostly occurred in an acute form; they were brought on by the emotional excitement of battle, and, in his experience, had a basis of asthenia. He divided them into seven groups: (1) Acute nervous asthenia, mostly in the form of neurasthenia and psychasthenia; (2) hysteria, of which there were many varieties manifesting themselves in dumbness, stammering, tremor, paralysis, convulsions, catalepsy or somnambulism; (3) depression, showing itself sometimes as simple sadness, at others as delirium with ideas of suicide; (4) stupor, sometimes simple, sometimes accompanied by catatonic phenomena recalling those of dementia praecox; (5) hallucinations, coming on in a transient form after emotion; (6) confusional states, having the characters of amentia; (7) in rare cases, maniacal excitement. All forms of war psychosis in the strict sense are, in Morselli's experience, curable within a short period if treated early; it is important, therefore, that the diagnosis should be made at once within the war zone. It is better that a soldier whose mind has been deranged by the conditions of military service should not be sent to a lunatic asylum unless the case proves refractory to early treatment. The author points out the difficulties presented by more or less conscious simulation. It is in dealing with such cases that the experience of the psychiatrist is most

useful as, without special knowledge, mistakes are easily made. Once the doctor has made up his mind that the soldier is shamming, the best plan is to send him back to the fighting line. The results of treatment in the psychiatric stations within the war zone are very satisfactory. In some forms of psychosis the proportion of cures within the first ten days is sixty per cent.

WAR "REACTIONS."

CHAVIGNY (*Paris méd.*, January 1st, 1916), says that soldiers on active service are peculiarly liable, under the strain of the number and variety of the duties imposed upon them, to show mental breakdown by "reactions" which expose them, if their nature is not recognized, to be punished for breaches of discipline. Temporary loss of memory may make a man forget that he is a soldier and leave the trenches, with the result that he is court-martialled; the same thing may happen in cases of deaf-mutism from shock. The reactions of real insanity are shown by desertion, abandonment of post, refusal to obey, breaking of arms and destruction of equipment, burning of buildings, mutiny and acts of violence. These offences include almost all those which under military law are visited with increased penalties in time of war. Chavigny relates several illustrative cases in which an expert examination saved men from death, and obtained for them a recognition of unfitness for military service. Chavigny insists that simulation is relatively rare, and he strongly urges the doctor, even when a case looks most suspicious, not to allow himself to be carried away by a first impression. He should carefully observe the man, not letting him, or any one about him, know that he is under suspicion. The expert must remember that a mistaken diagnosis of simulation justly exposes him to the severest criticism. But having made up his mind that the case is one of malingering, he should act without hesitation. The author relates a curious case of what

he calls supersimulation. A censor of correspondence from the front intercepted a letter from a soldier to his wife, in which he told her not to worry about him when she was informed that he was in hospital, as in order to get away from the firing line, where he ran too much risk, he was shamming deaf-mutism. He instructed her how she was to answer all questions in case of inquiry, so as to give a convincing history of hereditary and personal antecedents. The man at this time had been under Chavigny's care, and was being treated for typical deaf-mutism caused by shell shock. All the classical symptoms were present—local anaesthesias peculiar to such cases, persistent cough, etc., besides loss of speech and hearing. Examination after cure of the deaf-mute condition showed a very marked state of mental inability. But more typical than this, inquiry of the man's family doctor confirmed the absolute reality of the hereditary and personal history which, in his letter to his wife, he had described as invented to suit the requirements of his case. The wife, on close examination, confessed that her husband was the victim of his imagination, as it often happened that he could not distinguish his own inventions from what he had actually seen. He was, in fact, a mythomaniac, who doubtless in order to give himself some importance had invented a disease from which he really suffered. Ravaut, as the result of a series of puncture experiments in cases of mental disturbance caused by the war, had pointed out the frequent presence either of abundant albumin or blood in the cerebro-spinal fluid in men who for the lack of objective symptoms might have been put down as simulators. Chavigny thinks this may be a useful help in diagnosis, but only if the result is positive. He has seen it negative in cases as to the genuineness of which there could be no doubt. Furrowing of the nails, dating from the appearance of nervous or mental disturbance, may be important in cases of late or retrospective examinations.

WAR MUTISM.

At a meeting of the Medical Society of Parma in November, 1915, L. Roncoroni reported four cases of war mutism (*Il Morgagni,* May 10th, 1916). Two of the patients had an evident predisposition to mental disease, one of them having attempted suicide some years before, while the other at the age of sixteen, after seeing an apparition of a woman clothed in white in his room at night, remained three days without being able to utter a word. The affection also occurs in non-combatants; one of the patients was an orderly, and another a chauffeur employed in collecting wounded. Although the condition is known as war mutism, in the author's cases there were other phenomena—sensory and motor, organic and psychic—besides the loss of speech. One man was the subject of automatic motor symptoms with rhythmical movements of the head—flexion, extension, and from side to side—and twisting of the trunk, which lasted four days consecutively. Two had some muscular hypertonia, especially in the lower limbs; in three there was definite diminution in sensitiveness to pain. In one there was exaggeration of reflexes superficial and deep, and immobility of the eyeballs, so that the man seemed to be always staring at one point. There was an arrest of all the higher psychomotor functions. In the first days the patients were motionless, and incapable of reacting to external stimuli, or manifesting a spontaneous activity except in regard to taking food and emptying the rectum and bladder. In most cases sleep was not disturbed. The power of writing was always recovered before that of speech. In three cases the more important symptoms disappeared after three to ten days, and in a fortnight or three weeks cure was complete, except in the case of the man who had previously attempted suicide. In all the cases there was loss of memory, which lasted some days. Roncoroni holds strongly that war mutism is not hysterical in nature.—An epitome in the *British Medical Journal.*

NERVOUS AND MENTAL SHOCK.

We are indebted to Lieutenant-Colonel William Aldren Turner, M.D., R.A.M.C. (temp.), F.R.C.P., Physician to King's College Hospital and to the National Hospital for the Paralysed and Epileptic, London, for the following account of the arrangements for the care of cases of nervous and mental shock among soldiers coming from overseas:

Cases of nervous and mental breakdown due to shock, fatigue, exposure and the other conditions incidental to a campaign, began to arrive in England in September, 1914, shortly after the commencement of hostilities. The cases showed a varied symptomatology, but could be classified into three main groups. One group was recognized whose symptoms were due to the bursting of high explosive shells in the immediate vicinity of the patient or to the secondary effects of the explosion, such as burial under earth and débris or the inhalation of noxious gases. The second group included cases of a general neurasthenic character (using this term in its widest sense) attributable to exhaustion of the nervous system resulting from physical and nervous strain, sleeplessness, fear, anxiety and harassing sights and experiences. The third group included cases of mental breakdown—the milder as well as the more severe psychoses—mental confusion, mania, melancholia and delusional and hallucinatory psychoses.

At the commencement of the war the cases of nervous shock and neurasthenia were transferred from overseas in company with medical and surgical cases, and were treated in the general wards of the hospitals at which they arrived, while the cases of mental disorder were transferred to D block, Netley, the established institution for the treatment of mental patients in the service of the army.

As cases of nervous breakdown of all kinds were com-

ing over in considerable numbers in consequence of the severe fighting during October and November, 1914, and as it was deemed desirable that special provision should be made for their treatment, Sir Alfred Keogh commissioned a special medical officer to proceed to France to report upon the cases—their nature and numbers and the conditions under which their treatment should be carried out to the best advantage both during the preliminary stages in France and afterwards on their arrival in this country. The general purport of the report was to the effect that the cases of nervous shock and neurasthenia should be given treatment in hospitals for nervous diseases and in special institutions provided for the purpose, under the care of physicians with special neurological knowledge. In consequence, arrangements were made whereby cases of neurasthenia and nervous breakdown were labelled on their departure from the base hospitals by medical officers with special qualifications for this work, and were transferred directly to the special hospitals and institutions provided for their treatment at home. By these means cases of functional paralysis, neurasthenia, and the milder psychoses were separated as early as possible from cases of severe mental disorder.

The special institutions were the hospitals for nervous diseases and the Red Cross Military Hospital, Maghull. This institution, which was built to meet the requirements of the Mental Deficiency Act, was handed over to the War Office in December, 1914, as it was necessary to have a hospital suitable for those "borderline" cases which required more special supervision than could be given in hospitals. It was desirable, also, to provide an institution to which mental cases might be sent from D block, in order to obviate their transference to public asylums—a policy which was adopted in view of the special circumstances attending the cause of the disorders The Military Hospital, Maghull, being built upon the villa pattern, provided the requirements of these

cases. To meet the increasing number of cases, further institutions were added at later dates to those just mentioned, namely, the Springfield War Hospital for severe and protracted cases of neurasthenia and "borderline" cases, and the Napsbury War Hospital for cases of acute mental disorder requiring asylum care and supervision.

Clearing Hospitals.

In order that all cases should receive a short period of rest and treatment on their return from France before being transferred to the most suitable institution for final disposal and treatment, two "clearing" hospitals were established early in 1915. These were:

1. *The Neurological Section, Fourth London Territorial General Hospital.*—All neurological* cases, labelled as such at the British base hospitals overseas, were transferred to this section. There they received a short probationary course of treatment, with the result that a large number recovered rapidly and in due course were returned for light duty. A certain number, however, were of a more serious and protracted character. These were transferred eventually to one of the hospitals provided for the purpose—namely, the Maghull or the Springfield War Hospitals. In the event of a patient becoming insane, he was transferred to D block, Netley, or to the Napsbury War Hospital.

2. *D Block, Netley.*—All cases of acute mental disorder arising in soldiers overseas were transferred to this section. After a short period for observation and discriminatory sifting, the cases were transferred, on the one hand, to Napsbury War Hospital, should they be considered of a certifiable character and to require care and treatment under asylum conditions; on the other

*The term "neurological" is used here to refer to *unwounded* cases suffering from neurasthenia, the functional paralyses, hysteria and the milder psychoses.

CENTRE DAY ROOM, HOSPITAL FOR INSANE, WHITBY.

hand, to the Maghull or Springfield War Hospitals if of a non-certifiable character but requiring more care and supervision than could be obtained in a general hospital.

Neurological Sections.

The foregoing is a brief review of the provision for the cases of nervous and mental breakdown up to May, 1915. For some time before this date it had been noticed that a considerable number of neurological cases were coming from overseas directly into central and auxiliary military hospitals scattered throughout the country. Partly to meet the needs of these cases and partly to provide additional accommodation for the increasing number of cases, the Director-General established Neurological Sections in all the Territorial General Hospitals throughout England, Scotland and Wales (May 24th, 1915). These sections were officered where possible by physicians specially versed in nervous diseases. The primary object of these sections was to furnish the same probationary course of treatment to the cases on arrival at the Territorial General Hospitals as was given in the clearing hospitals, and to bring in all cases from the auxiliary hospitals in which suitable or sufficient treatment was not available. Moverover, cases of a serious or protracted nature, or cases requiring supervision of a special character, could be transferred from them to the Maghull or Springfield War Hospitals.

Scotland.—With the introduction of Neurological Sections into the Scottish General Territorial Hospitals it was considered advisable that a special hospital should be provided in Scotland. Through the assistance of the Scottish Branch of the Red Cross this was forthcoming in the Royal Victoria Hospital, Edinburgh, which has continued to provide accommodation for cases of a neurological character.

Netley.—At the same time a Neurological Section was formed in the main hospital building, Netley, the chief

object of which was to permit of the removal from the convoys arriving at D block from overseas all cases which the medical officers there considered did not require supervision of a special kind, as some cases had so far recovered on arrival at Netley as to be deemed suitable for treatment in a neurological rather than in a mental section.

The Disposal of Patients.

In order to understand fully the arrangements existing at the present time for the care and treatment of unwounded soldiers suffering from nervous shock, neurasthenia and mental disorder, let us follow from overseas two or three hypothetical patients to their final destination in this country.

On arrival at one of the British base hospitals abroad, the soldier's condition is investigated by a special medical officer. The patient then is sent to a section of a hospital according as his symptoms are of a neurological or a mental character. Should he be suffering from transitory mental symptoms which subside rapidly, he is transferred from the mental to the neurological section as soon as it is advisable to do so. In order to meet this class of case special accommodation is now being provided at the base hospitals overseas, so that the patient may be placed under the most suitable circumstances for rapid recovery. The patients are labelled for transference to one of the clearing hospitals at home—if neurological, to the 4th London Territorial General Hospital, or the Neurological Section, R.V.H., Netley; if mental, to D block, Netley.

Neurological Cases.

On arrival at one of the clearing hospitals just mentioned, or at a neurological section in any Territorial General Hospital, the patient is given treatment. If his symptoms are slight or transitory and disappear rapidly, he is sent on furlough and later is returned to light duty.

On the other hand, should the course of the disorder be less favorable or should symptoms develop which require special supervision, or if it is the opinion of the medical officers that the case is likely to be protracted, or to require special treatment not available in the section, the patient may be transferred to one of the special hospitals for nervous diseases or to a special institution: (*a*) to the Military Hospital, Maghull, for the Northern and Western Commands; (*b*) to the Springfield War Hospital for the Eastern, Southern and Aldershot Commands; (*c*) and to the Royal Victoria Hospital, Edinburgh, for the Scottish Command. If the patient is under treatment at one of the hospitals in the Irish Command, he may be transferred to the King George V Hospital, Dublin.

If for various reasons it has not been possible to send patients home through the clearing hospitals so that they arrive directly from overseas at central or auxiliary military hospitals in which there is no neurological section, or to which no medical officer with special experience is attached, a short period of treatment is given, but should recovery not take place within two or three weeks, the patient is transferred for treatment to the neurological section of the nearest Territorial General Hospital.

From the preceding account it is evident that every case of nervous shock and neurasthenia coming from overseas is given a short period of rest and treatment in the hospital at home at which he arrives. In many instances this period is sufficient to permit of recovery. In other cases sufficient opportunity is provided to study the symptoms with a view to the transference of the patient to one of the special institutions should this further step be necessary.

Mental Cases.

On arrival from overseas at D block, Netley, the patients are examined by the special medical officers

attached to the hospital. All cases which are considered to be of a neurological character are removed for treatment to the Neurological Section in the main hospital building, Netley. All patients suffering from the severer psychoses of a certifiable type are given two or three weeks' probationary treatment in D block. If no recovery has taken place during this time, they are transferred to the Napsbury War Hospital, or to the Dykebar War Hospital, Paisley, if their domicile is in Scotland, or if they belong to Scottish regiments.

No mental cases are transferred directly to Ireland, but special arrangements have been made recently by which overseas cases of mental disorder arriving in Ireland may be treated in a villa attached to the Richmond District Asylum.

The number of cases which recover during their stay in D block and are returned to light duty is negligible, but a certain number recover sufficiently during their stay there to be no longer considered as of a certifiable character. These latter are transferred to the Red Cross Military Hospital, Maghull, or the Springfield War Hospital, for further observation and treatment.

A short account may be given of the institutions to which reference has been made, the general character of the cases retained for treatment, and the percentage of cases returned to light duty.

Fourth London Territorial General Hospital.

The Neurological Section of the 4th London General Hospital is the largest of the Neurological Sections, and in addition to receiving the majority of the neurological cases sent home directly from overseas, it accepts patients transferred from central and auxiliary military hospitals in the London district and adjoining counties. It contains 400 beds. An important division of the section is the Maudsley Hospital, which is especially well adapted for the care and treatment of soldiers suffering

from all forms of traumatic neurasthenia, hysteria and the milder psychoses.

Netley.

The Neurological Section of the Royal Victoria Hospital, Netley, occupies several wards in the main hospital building, and consists of about 100 beds. It serves a most useful purpose in taking over for treatment cases which have been sent from overseas to D block, but which require no longer the special supervision provided there. Cases are sent also directly to the section from overseas.

The type of case observed and treated in these sections is similar. They are: Most forms of functional paralysis, especially paraplegia, disturbances of speech and articulation, amnesia or loss of memory, the effects of terrifying dreams, mutism, deafness, deaf-mutism, amblyopia, "bent-back," tremblings and motor agitations, tic-like movements, sleeplessness, nervous debility, indecision, loss of self-confidence and the milder forms of neurasthenia, simple mental confusion, the anxiety psycho-neuroses and simple mental depression.

The treatment adopted consists chiefly of rest and feeding; massage, and electrical applications in suitable cases, baths, when these seem indicated, and psychotherapy in the form of simple suggestion and occasional hypnosis.

In a general way the results of treatment at the Fourth London General Hospital show 40 per cent. of cures and 20 per cent. transferred for further treatment to the special institutions.

The Special Institutions.

The Red Cross Military Hospital, Maghull, and the Springfield War Hospital are constructed on somewhat

similar lines in that they are provided with single rooms and special accommodation for cases requiring isolation and supervision in addition to day rooms and dormitories.

The Maghull Military Hospital had not been used for the treatment of patients before it was taken over by the War Office, but the Springfield War Hospital had been employed as a hospital for defective children for about ten years.

The available accommodation in the two hospitals amounts to about 550 beds. No case is admitted directly from overseas to either of these institutions, as all cases have received a course of treatment at one of the military hospitals at home before transference. The patients most suitable for treatment in these institutions are cases of neurasthenia of a severe or protracted character, the milder psychoses, such as simple melancholia and the anxiety psychoses, psychoses with obsessions and fears, profound amnesia, epilepsy, high grade mental defectives, the milder types of primary dementia, and all cases of a functional character which do not lend themselves to treatment in a general hospital.

Treatment is conducted upon general lines—rest, feeding, indoor and outdoor recreation, and massage in suitable cases. At the Maghull Military Hospital a form of psycho-analysis has been used with benefit in selected cases. The results of treatment at Maghull show about 40 per cent. of cases returned to light duty.

The Mental Hospitals.

Napsbury War Hospital and Dykebar War Hospital, N.B., receive the majority of their patients from D block, Netley; but Napsbury admits mental cases also from military hospitals in the Southern Command and the Midland counties; Dykebar admits also from military hospitals in the Scottish Command and the Northern

counties. The Napsbury War Hospital is the hospital section of the parent asylum; Dykebar is one of the most recent of the Scottish asylums, built upon the villa pattern. The available accommodation in the two hospitals is about 700 beds.

The patients transferred to these hospitals are of a certifiable type and include most of the severe forms of acute mental disorder—the confusional psychoses, mania, the graver melancholias, acute delusional and hallucinatory psychoses, dementia praecox, mental deficiency with confusion, general paralysis of the insane, and epilepsy with mental symptoms.

In accordance with accepted policy, none of the patients in these hospitals is certified as a person of unsound mind. Each patient is given a reasonable period of treatment with a view to recovery.

In consequence, however, of the accumulation of chronic and incurable cases which was observed a few months ago, it was decided to board and discharge to asylums all cases of general paralysis of the insane, of epilepsy with insanity, and all patients who had been in asylums prior to enlistment. A certain number of chronic cases also are boarded and discharged to asylums if no improvement is recorded after a fair and reasonable period of observation and treatment.

It is obvious from the nature of the disorders that the percentage of cases returned to light duty must be small, but the figures from the Napsbury War Hospital show from 10 to 15 per cent. of cases discharged to light duty. —*The British Medical Journal.*

ANOTHER CASE OF PELLAGRA IN TORONTO.

By Dr. Claude A. McClenahan,

Assistant Physician, Hospital for Insane, Toronto.

The protean and varied characters of this disease and the great rarity in our country makes the few cases we see very interesting and instructive. So far those that have been reported in Canada have come within the scope of our Hospitals for the Insane. These have all died after a few months' residence, but at present this case has gone home, and from latest reports is in very fair health.

Pellagrists speak of three different types of this disease; the intermittent, appearing at intervals between which the patient is well; remittent, when disease is worse at certain seasons and never entirely well; continuous, showing no improvement and soon reaching a fatal issue. This one under discussion would fall into the intermittent form with a likelihood of a recurrence later.

While at present Pellagra is not showing any tendency to invade our country, we must remember that in the Southern States, during recent years, it has increased from rare cases to many thousands, and shows even greater increases among the congested populations of Southern Europe and Northern Africa, and has led to the appointment of special commissions to deal with it.

Considering this great increase, it is well for us to be on the alert and ready to recognize it and adopt the latest measures used for its prevention and relief.

Case Report.

Admission Note.—Patient is 44 years of age. Married. American. Protestant. Admitted December, 1915.

Family History.—Father died at 68 years from heart disease. Mother died at 62 years from pernicious anæmia.

Brothers, four, all over 35 years and healthy. Eight younger brothers died in infancy.

She has one child living, age 19 years. She was sick three months following her birth. In her ancestry one brother was an alcoholic, and is now here. Her husband has locomotor ataxia, dating back for fifteen years.

Personal History.—Mrs. M. was born January 28th, 1871, in Cincinatti. Her father was a signwriter. She attended school; was attentive in her work and learned readily. Afterward lived at home until her marriage at the age of twenty-four years, and then came to Toronto, where she has resided since. She was a good worker; rather excitable disposition and impulsive, but never contrary or fanatic. She attended church regularly, was always of good habits, but she showed a tendency to worry over things. There is a history of four or five operations for fibroids, dating back over the last eight years.

Present Illness.—In September, 1915, patient began to get nervous, emotional and often depressed. She worried over her husband's illness and financial troubles. She began to go out alone; was very irritable and suspicious, thinking people were making trouble for her, and afraid that she was to be taken away. She said everyone was scheming against her, and she would cry over this for long periods. She imagined she committed some great crime and the officials were searching for her. There was great confusion, as she thought she had large sums of money and her memory became very poor.

She lost her appetite, and would often refuse food altogether. At this time she complained of numbness in her arms, and there developed a dryish brown rash on the sides of her neck and both arms. This was termed ichthyosis, and cleared up in a couple of weeks. She was in a number of hospitals previous to admission here.

Physical Examination.—This patient was a somewhat poorly nourished, but well-developed white woman. There was great general weakness and some anæmia.

Skin at time of admission was healthy. In a few weeks a recurrence of the previous skin lesions mentioned above took place. On the back of the hands and up the front of the wrists a peculiar dry, brownish condition developed. She did not complain of it being itchy, but it seemed to worry her a great deal. Her friends say it was exactly similar to her attack in September, 1915, which they thought at that time was due to sunburn, as she had been employed picking berries shortly before the attack. Parts exposed to sun rays are generally affected. The skin remained thick, dry, leathery, with fissures developing marking it off with irregular patches. It never reached the palms of the hands and gradually disappeared by desquamation in about six weeks.

Eyes.—Pupils were very small; had sluggish reaction to light, but reacted to distance.

Ears—Hearing good, with some watery discharge from the right ear for a month.

Gastro-Intestinal Tract.—At home there was a distaste for food, and all her life she would never eat meats. Otherwise her diet at home seemed ordinary. Upon admission here she had to be spoon-fed and her appetite became ravenous. No matter how much she ate she was never satisfied. Along with this there was an intense thirst, and she was continually calling for water. This condition lasted for about two months, when these symptoms disappeared. Her lips were dry and cracked with a number of small sores at the outer edges of the mouth. The teeth were well preserved, but covered with sordes. The tongue was dotted with small red spots along the top and sides. She suffered from diarrhœa varying in intensity, often having five movements daily. The fæces were very offensive and of a watery nature.

Her ordinary weight was 145 pounds and this went down to 103 pounds.

Urine.—Had a specific gravity of 1033; dark amber color; slight traces of albumin and a sediment containing ammonium urates and uric acid crystals.

Blood.—Showed 4,352,000 red cells and 4,800 white cells. Wassermann on blood and spinal fluid negative.

Reflexes.—The biceps, triceps and supinator of both arms were almost absent. Knee jerks were accentuated. Plantar response present.

Gait.—Had gradually changed about three months before admission. It was shuffling in nature; she had to be helped; could not turn quickly and she walked bent over with short, unsteady steps, showing a tendency to fall forward. Had some Rhombergism. Sensation unimpaired.

Psychic Phenomena.—At first her friends described her as becoming gradually irritable and suspicious of them. Often showed outbursts of this while here and would complain of ill-attention; threatened the nurses; using very vile and disgusting language. When under our observation the predominant feature was an almost persistent gaiety. She felt "fine"; would tell of splendid trips; often stopped at the Windsor Castle with her aunt, Queen Alexandra. To-morrow she was starting for Florida, was taking everyone with her; had billions of money and called herself Lady X. She placed orders for expensive automobiles to be used on her wedding tour around the world, in which she was to visit all the crowned heads of Europe. In fact her ideas of grandeur and elation formed a most ideal paretic picture and one was struck by the remarkable similarity of these two forms of mental disease.

Hallucinations annoyed her very much. She was constantly telephoning her daughter; could hear her doctor and family answering her requests; would point to them excitedly, saying "there they are" and ask to have them taken away.

Mental confusion also existed; could not pay attention, was unappreciative of her condition and unable to carry on a coherent conversation. She knew where she was, but not the year nor the month and called the nurses by names of her former friends.

Her past life seemed entirely forgotten; she thought she had been here for seven years. Said her brother who was "dippy" had brought her here.

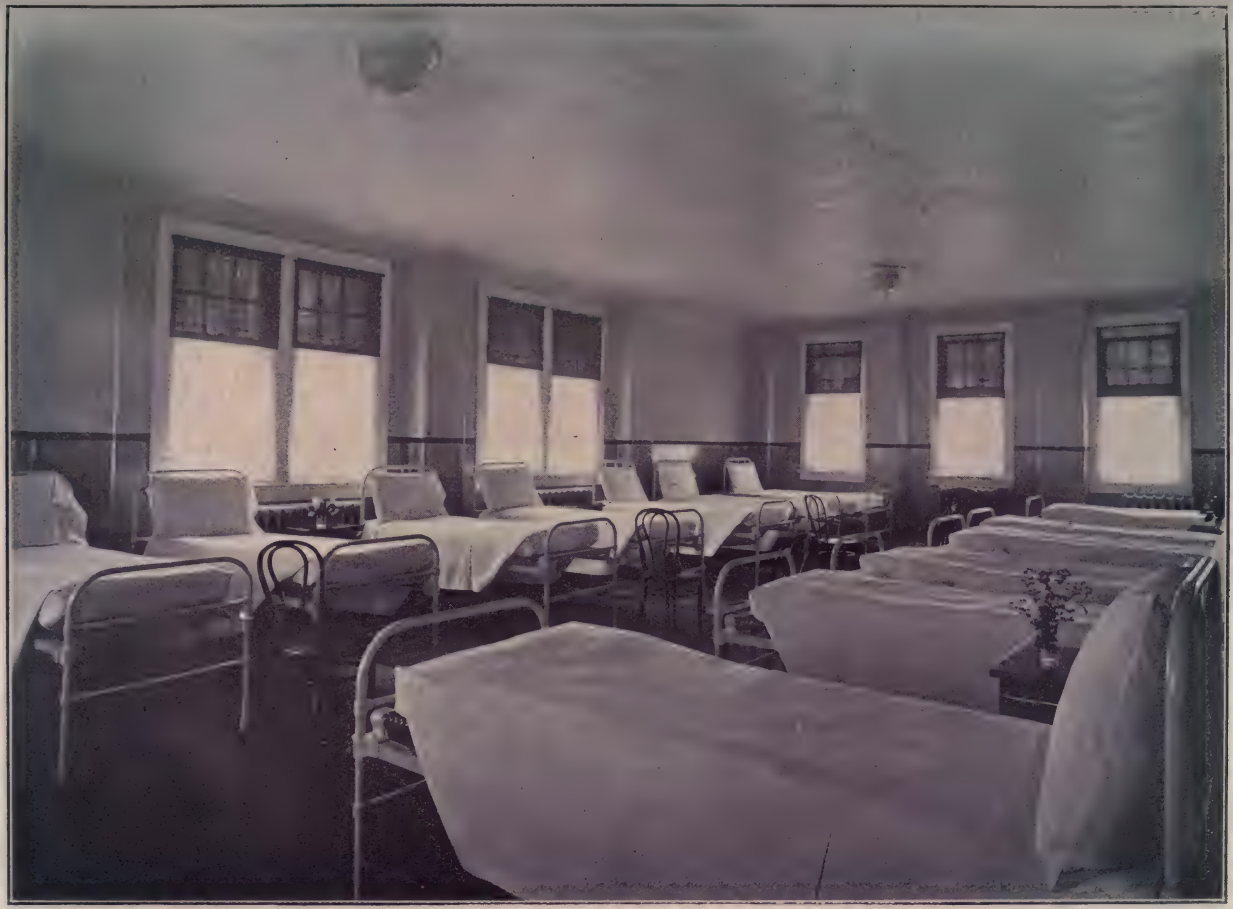
Emotionally.—She was elated, boastful, boisterous and noisy. Depression and fits of crying were noted at intervals. Erotism was seen; would disrobe herself; suggestive glances and grimaces were common.

Course.—After four months residence she became quieter; gradually the hallucinations and delusions left her. The diarrhœa ceased. She gained in weight about fifteen pounds. Her gait improved, but was never normal. At the present time her friends report her as keeping quite well; able to go out on the streets and help herself.

Treatment.—Required baths and packs during the restless periods. Tonics were given. She had the ordinary diet with plenty of milk and eggs. When getting well she began to relish meat, a thing which she had always detested, but now is able to enjoy.

Conclusion.—This case presents quite well the pellagrous triad of symptoms, namely: the cutaneous, the digestive and the mental. I regret not having some photographs of the skin lesions.

In studying this case I derived much help from Dr. Forster's reports of two previous cases in this hospital, which appeared in the September BULLETIN of 1914.



A Ward, Hospital for Insane, Whitby.

THE WISH COMPLEX IN THE HALLUCINATION

By G. H. J. Pearson, A.B., M.D.,

Assistant Physician, Hospital for Insane, Mimico, Ont.

Three theories have been advanced for the cause of hallucinations—that of Tamburini, that of Tanzi and that of Gordon. That of Tamburini[1] is that hallucinations "are dependent upon an irritable state of the psycho-sensory centres, analogous to that which in the psycho-motor centres produces epilepsy. The disturbance of the sensorial centres arouses the images that have been deposited there in an unconscious state in simple or complex forms, according to the extent of the stimulation, and in a manner that the more closely resembles reality the more intense the stimulus. In short, whatever may be the origin of the morbid action, the seat of the hallucinatory phenomenon is always the same, namely, that part of the cerebral cortex that perceives the actual sensations, and is able, independently of where the stimulus comes from, to reproduce them more or less vividly in mnemonic form.

This takes place in three ways, namely, by anomalous excitation of the peripheral sensory apparatus and transmission of the stimulus along a centripetal nerve, or in consequence of a delusional idea that affects the sensorial centre, or by a local irritation that acts upon this directly."

To Tanzi[2] it does not seem probable that irritation of the sensory cortex could produce anything but elementary hallucinations. Especially this theory seemed to be deficient in explaining the hallucinations of vision, as the visual centre of one hemisphere could give only a half

[1]Tamburini—Revue Scientifique, 1887.

[2]Tanzi—Textbook of Mental Diseases (English Edition, 1909) page 122.

image and the irritation must be imagined to stimulate complementary areas of the visual cortex and the subsequent images to fuse themselves into one. To correct this objection he devised a theory stating that "we may consider that an hallucination takes origin as an idea or symbol, or as a more or less conscious fragment of an idea in the associative area, but that, instead of forming associations with other ideas, or of projecting itself externally in movement, it flows back, either along the same homolateral and contralateral fibres by which it came, or in some other way yet to be determined, to the sensorial centres from which it proceeded when it was of the nature of a sensation. Thus it becomes what it originally was, namely, a sensation; but it is a sensation of a pathological character on account of its unusual origin.

This power of retrograde expansion, which inverts the habitual relation between the sensorial centres and the centre of representation, is accordingly the special morbid character that determines the individuality of hallucination, both as a psychological phenomenon and as a clinical symptom. The sensorial centres are importers in relation to external objects, but exporters in relation to the internal domain of transcortical thought. If, owing to a pathological inversion of the habitual relations, they import from within, it is natural that they should react in the only manner in which it is possible for them to react, namely, by the production of sensorial images."

Gordon[3], following Esquirol[4] considers that hallucinations are purely psychic phenomena consisting of ideas reproduced by memory from the past life and rising from the subconscious.

The theory of Tamburini may be refuted at once, as it has been so ably analyzed by Tanzi[5]. Tanzi's own theory explains the transmission of the hallucination to

[3]Gordon—American Journal of Insanity, Vol. LXX, page 883.
[4]Esquirol—Des Maladies Mentoli, 1838.
[5]Tanzi—Textbook of Mental Diseases, page 125.

the sense centre and its conversion into a sensation, but it does not explain how from this great medley of images occupying the representational centre the particular one noted in the hallucination is selected. Gordon goes further in this direction when he says the hallucinations that he is explaining are past experiences repressed into the subconscious and redepicted. Anyone with experiences with the hallucinations of the Psychoses will realize that this does not answer for them, as the experiences they depict are far from being past experiences of the patient.

Hallucinations bear a great resemblance to dreams. In the dream state the dreamer lives through a fulfilment of some wish that, because it is objectionable to the waking, present day ideas of morality, is repressed. The hallucination is very similar. We have three disturbances of perception—illusions, hallucinations and dreams. These bear relations to each other. The illusions might be explained as being the fulfilment of a conscious wish. How often has one stood waiting for a friend and seen that friend approach many times, only for the resemblance to fade as soon as the passerby was close. The wish that this should be the friend had so influenced the senses that they depicted the stranger as the friend. This is the most obvious conscious-wish-fulfilment illusion, but there are many grades to pass between the conscious wish and the subconscious wish. Among these levels we come to that of a preconscious. The illusions resulting from a preconscious wish might be exampled as that of a stranger on the street taking on the resemblance to a friend whom, in the centre of consciousness, you were not thinking of, but whom, in that fringe that divides consciousness from subconsciousness that I have designated the preconscious, after careful analysis, you might be found to be wishing to meet. As I said before, the subconscious wishes are realized normally in dreams. Some wish complex of the dream, repressed because it

is in contravention of the Herd instinct, is passed by the censor into dream consciousness, and so receives a partial fulfilment. These are often of a sexual nature.

In the toxic psychoses with hallucinations, namely, epilepsy, alcoholism and dementia præcox, we have as a symptom a greatly increased sexual desire. A great number of ways are utilized to satisfy this—sexual excesses, perversions and masturbation. As the sexual power deteriorates other means are sought. Masturbatory movements, such as rubbing the head, arise, and at this time hallucinations develop. Irritation of the representational centres by the overflowing sexual impulses send stimuli to the sensation centres. The subconscious decides what images shall be perceived, and these fulfil the sexual wish, but the Herd instinct still rules in the subconscious, and the images are symbolic, even the affect tone may be fear instead of pleasure, as often happens in dreams. (That these are not always fear inspiring, though apparently so, is of common note; witness the apathetic reaction to the fearful hallucinations of dementia præcox.)

Case 1: D. B., an Epileptic with pre and post paroxysmal excitement and psychic equivalents. During this pre paroxysmal agitation he saw two snakes, one with yellow stripes, which entered through the top of the door, and crawling down, pierced his feet and worked their way up to his shoulder. Following this he felt a sensation of falling, as if from a great height. This caused great terror. Shortly afterwards he saw a skunk in the corner of his room and an Indian waving a flag. With these hallucinations he expressed many sexual thoughts. To anyone familiar with the symbolic interpretation of dreams these hallucinations need no explanation, but their repressed sexual content is self-evident.

Case 2: M. F. T., Dementia Præcox Hebehrenic. Her hallucinations are mostly auditory. She hears men's and women's voices accusing her of sexual perversions

and irregularities, and urging her to commit suicide. They say that she must commit a sexual perversion with one of the staff or she will never be released. Her whole life has been a sexually irregular one from the time she was fourteen years of age until she was brought to this hospital. These auditory hallucinations show deep repression, and the censor has greatly altered them. The accusatory voices are really voices of her former companions, and she wishes that she could either be dead or else back in the life she led before, i.e., as a prostitute. She realizes that any sexual experience would be as agreeable to her as her release. She has visual hallucinations of women in low-necked black dresses and men dressed in white togas, such as the Romans wore—which may symbolize homosexuality.

Case 3: F. W., Alcoholic. He has hallucinations of many spheres. Men enter his room at night and beat him unmercifully across the thighs. They threaten to castrate him because of his actions with a certain hotelman's wife. His whole life shows a history of alcoholic and sexual excesses. These hallucinations are more repressed. The threats made by the men may symbolize a homosexual complex with sadistic tendencies.

Case 4: W. J., Dementia Præcox Paranoid. This patient hears voices, usually women whom he has known in the past and about whom he expresses many sexual thoughts. These voices refer continually to the sexual field and also threaten him. He suffers at the same time with painful sensations in the right testicle and penis. This pain he claims to be due to an electric current. The right side of his face and his ear hurt him. He had a vision of a young man coming into his room to wrestle with him. Throughout this patient's life there is a history of sexual irregularities, culminating previous to his admission in peculiar experiences of impotence. The hallucinations of hearing in which women refer to sexual experiences are self-evident wishes for such experiences.

The painful sensations symbolize a desire that these sensations should be agreeable. The vision of the young man is evidently symbolic of a sexual wish.

Tamburini likens hallucinations to a sensory epilepsy. McRoberts[6] refers the epileptic seizure to the fulfilment of a subconscious wish that the epileptic may withdraw from this world, the wish being dependent on a special condition of the cortex and the incitement being due to some toxin.

Similarly hallucinations are due to a wish to withdraw from the present life into one more full of sexual experiences, the irritation being set up by a toxin.

The irritation, from whatever toxin it arises, stimulating the sexual centres and causing increased desire, with the failure of normal satisfaction, sets up a stimulation in the cortex which causes an impulse to flow from the representational centre, bearing with it an image that represents a sexual complex. The appearance of the hallucinations in consciousness produces the fulfilment of the wish, and so satisfies the subconscious mind whether the affect content is pleasant to consciousness or not.

This theory has some bearing on the treatment. Hallucinations are one of the most distressing symptoms we have to deal with in the psychosis. By a careful psychanalysis of these patients it may be possible to rid them of their sense deceptions, and so aid them to exist with greater happiness and tend to the production of an improvement in their total mental condition, if not to their ultimate cure. Especially does this apply to Dementia Præcox.

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[6]McRobert—Med. Record, May 13, 1916.

THE CAUSATION AND CURE OF CERTAIN FORMS OF LUNACY.

By Rupert Farrant, F.R.C.S., Captain R.A.M.C.,

Late Hunterian Professor, Royal College of Surgeons.

Before going on foreign service for a second year, I wish to publish the following preliminary conclusions and summary of work directed to the causation and cure of lunacy carried on during the last seven years. The work is a continuation of that previously published on the thyroid gland in the elucidation of goitre and exophthalmic goitre.

The work consists of the microscopical examination of sections taken from the pineal, pituitary, thyroid and sexual glands—first, at different ages and periods of life such as puberty, menopause and childbirth; secondly, the effect induced in these glands by the acute and chronic toxaemias; and thirdly, the changes found in cases of lunacy.

Clinical examinations were carried out of cases exhibiting signs of enlargement and atrophy of these glands and symptoms of excess or diminution of secretion. Similar examinations have been made on all classes of lunacy for the presence of signs and symptoms. Photographs and X-ray examinations have been made to illustrate their occurrence. Mental cases and others have been examined for the presence of toxaemias inducing the alteration in the glands and the consequent induction of symptoms of excess and deficiency. Bacteriological examinations have been made of the faeces of lunatics and the colons examined *post mortem*.

From some 3,000 sections it is found that these glands vary at different ages and periods of life; with advance of life they tend to atrophy.

It is found that the pineal reacts to certain toxaemias, the ultimate result of which is fibrosis. The pituitary

reacts in a similar manner, the terminal result of which is fibrosis; intermediate stages of hyperactivity are seen, and the formation of cysts and adenomata. The reaction of the thyroid to certain toxaemias with the induction of hypertrophy, cysts, and adenomata, I have already described in my lectures as Hunterian Professor in 1915. A comparison was made of such specimens with those obtained from cases of lunacy, apart from those in which a definite pathology has already been proved, such as general paralysis of the insane (other syphilis cases), meningitis, head injuries, etc. The effect of age and of the lethal toxaemias was discounted and the state of the glands in cases of lunacy determined.

In primary and secondary amentia atrophy of the pineal, pituitary, and thyroid were found in three main groups of cases. In dementia praecox an alteration was found in the glands which varied with the duration of the case. Alteration and degeneration was also found in other cases of dementia. In some cases of acute confusional mania, melancholia, manic-depressive and other forms of insanity, changes were found in the thyroid, pituitary, and sexual glands. The changes varied from hypertrophy to atrophy.

Clinical examinations were made of some 1,000 cases of insanity, analogous to those from which the pathological sections had been prepared, for signs of enlargement or atrophy, and the presence of excess or deficiency of secretion from these glands.

The thyroid gland was frequently found to be abnormal in children, adolescent and adult lunatics; its size varied from considerable enlargement to complete atrophy, and the general condition from one of hyperthyroidism and exophthalmic goitre to myxoedema and cretinism.

The pituitary gland was found sometimes to have given rise to symptoms of hyperpituitarism to apituitarism, in idiocy, dementia praecox, and other forms of insanity. Enlargement and atrophy of pituitary were deduced

from X-ray photographs of the sella turcica and clinoid processes.

Signs of alteration in the pineal were found, especially in children and adolescents, with consequent symptoms of hyperpinealism and apinealism.

Alteration was found in the sizes of the testicles associated with ductless gland changes. Testicular atrophy was well seen in cases of apituitarism. From the histories of cases it was deduced that the stimulation of the sexual organs or its sudden cessation was associated with altered mentality varying from mania to exhaustion psychosis; altered mentality was also found in cases of double castration. Hypertrophy of the prostrate was often found to be associated with altered mentality, and after complete removal cases were frequently associated with depression or melancholia.

Some 200 cases were examined for obvious signs of chronic toxaemia. Pyorrhoea and carious teeth were found to be a frequent accompaniment of lunacy in adults; in certain cases signs of chronic intestinal stasis and toxaemia were well marked.

Bacteriological examination of the faeces was made in some 100 cases for simple aërobic infections (apart from cases of asylum dysentery). Streptococci were found up to 100 per cent., and *Bacillus coli* was totally absent in some cases of mania. Streptococci were also found from vaginal swabs of puerperal mania.

Colons have been examined *post mortem,* and found to exhibit changes varying from normal to pericolitis, fibrous thickening of the walls of the gut, and atrophy of the mucous membrane, and in other cases dysenteric ulceration.

It is deduced that many cases of lunacy may be classified according to the toxaemia present and the change that it has induced in the ductless glands.

The effect of the toxaemia varies with the intensity, duration, and the age of the patient; the first effect is

stimulation, the final fibrosis. In the fetus and in childhood an acute or chronic toxaemia may induce atrophy of a ductless gland, and consequent maldevelopment and idiocy. Three groups stand out when the pituitary, pineal, or thyroid is atrophied. Cases of dementia praecox exhibit a polyglandular syndrome, and different gland types are to be found, and the appearance of the cases varies whether the gland is hypertrophic or atrophic.

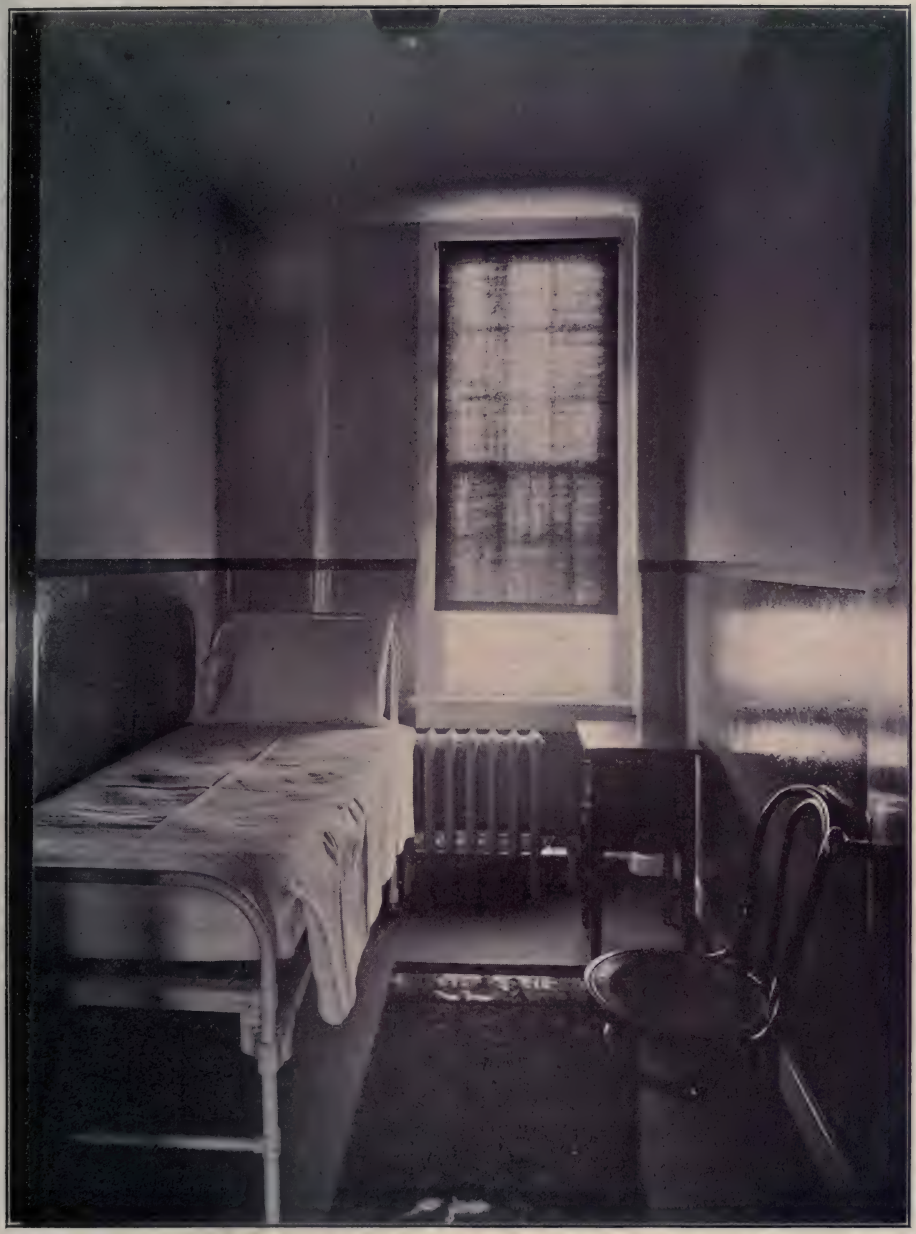
In adults certain toxaemias react on these glands, especially the thyroid and pituitary, and induce stimulation, hypertrophy and, finally, atrophy. The alteration in the amount of secretion—whether excess, deficiency, or absence—induces an altered mental state, and this, combined with the effect of the toxaemia, renders the patient insane or liable to insanity from slight mental stress.

Alteration in the sexual glands, whether primary or secondary, leads to altered mentality up to insanity.

The lines on which beneficial treatment may be carried out based on the above pathology become obvious; the matter may be summed up by saying that toxaemias, if present, should be removed by medicinal or surgical measures, and the glands allowed to involute if they are hypertrophied, or, if they are degenerated with deficient secretions, these secretions should be supplied. Good results may be expected before cortical brain lesions have taken place.

Careful experimental treatment with control cases is at present being carried out for me at Bethlem Royal Hospital by Dr. Phillips, commencing with the simpler medicinal treatment.

In a work of this nature due credit must be given to those who have so kindly given me pathological material and access to clinical cases. Full acknowledgment will be made when the work is published in detail. Dr. Braxton Hicks has supervised the collection of pathological material during the last year.—*The British Medical Journal.*



PATIENT'S ROOM, HOSPITAL FOR INSANE, WHITBY.

MENTAL CLINICS.

A LAW was passed in the State of New York in 1913 empowering the State Hospitals for the Insane to establish out-patient departments in the larger cities and towns of their respective districts.

Dr. E. H. Lewinski, in the *Modern Hospital,* gives the following brief statement of the advantages of such out-patient departments:

1. They contribute toward an early recognition of mental disorders.

2. They take care of convalescent patients discharged from the State Hospitals; they make possible earlier discharges from the hospitals and thus relieve the distressingly crowded conditions; and they also make possible the paroling of a large number of patients. Hitherto paroled patients have been outside the control of hospitals.

3. By making the out-patient departments integral parts of the State Hospitals, continuous care and treatment of certain types of cases is made possible at a much lessened cost to the State.

4. The visiting physicians and nurses and social workers of the clinic can straighten out many conditions predisposing to the loss of mental balance, and bring together a great many facts with reference to the environment of the patients, which might afford a better understanding of some of the causes of mental disturbance.

Ten of the fourteen State Hospitals have one or more mental dispensaries. In all, there are now thirteen dispensaries and eleven of them have field workers. It should be remembered, however, that two of the State Hospitals are devoted to the care of the criminal insane, and it is hardly possible that they could establish out-patient clinics.

The analysis of the cases attended at the various clinics in the State shows that the clinics reach the desired class of patients and are being freely used. It is important to bring this matter to the attention of physicians, that they may avail themselves of the opportunities which these clinics offer to the mentally unbalanced.

The Committee on Mental Hygiene of the State Charities Aid Association, which is in direct touch with the work, feels that there are several needs which should be met at the present stage of the development of the mental out-patient clinic system. These are as follows:

1. The need of official direction and responsibility for the work of the various dispensaries.

2. The need of uniform records and of regular and adequate reports by the Superintendents of Hospitals to the State Hospital Commission.

3. The need of coordinating the activities of the clinics into an effective system.

4. The need of establishing and maintaining high and uniform medical standards in all the clinics.

5. The need of establishing a division of prevention and after-care in the State Hospital Commission, to be directed by a physician especially trained in this kind of work.

THE RELATION OF FEEBLEMINDEDNESS TO OTHER SOCIAL PROBLEMS.

By Dr. Helen MacMurchy.

What are social problems? The difficulties and dangers which confront us as members of organized human society, whether it be in the small units of neighborhoods and communities or in the larger units of municipalities, sovereign states or provinces, nations or empires. As citizens who feel and acknowledge community responsibilities we must think and plan for public duty, public morality, public safety, public health, public welfare and prosperity.

It is evident that organized society rests upon the home. No home—No nation. If the problems of the home are satisfactorily solved we have a happy, permanent and prosperous state and nation. The home flourishes and is free under the protection of the state, and public health, for example, is secured by good public housekeeping, whereby pure water, pure air, pure food and healthy home conditions are secured for all citizens. It will be found that the problem of the feeble-minded is essentially a problem which begins, continues and ends in the home, if indeed it does not end the home, as often happens, for mental defect tends to destruction of any home where it appears.

Under the problems of public prosperity we must deal chiefly with industrial problems—unemployment, poverty.

Mental defect is a constant cause of unemployment. One feeble-minded man is often found in twelve different jobs in as many months. He seldom or never can keep a job unless he is in an institution It is the same with the feeble-minded woman. No matter how simple the work, or how anxious her employers are to keep her, or how kindly she is treated, or how often she is taught, she is out of a place all the time. One such woman who had friends and relatives to interest themselves in her, and

they *did* interest themselves in her, was employed in a laundry. Times were good, help was scarce, wages were high, but the laundry manager finally gave up the struggle, saying that he could not afford to keep her any longer. She could do the laundry work, but she was late so often that she never worked more than five days out of six at the best, and he could not teach her to be punctual.

Modern methods of preventing unemployment and poverty, such as vocational and industrial education, labor bureaus and industrial insurance, have little or no application to the feeble-minded. Their vocation is institutional life, where alone they can be employed and happy. If we would eradicate one of the chief causes of dependency and pauperism we must care for our mental defectives in a farm colony.

The poverty of the feeble-minded is proverbial. They never understand the value of money. They not infrequently get fairly good wages, but they cannot administer their income.

Near a certain town we had a family, all of whom apparently were feeble-minded—father, mother and children. The father had pretty good wages for a while—so they fell a prey to the "Instalment Plan." They signed papers promising to pay $1.00 a week each respectively for a sewing machine, certain expensive furniture, an organ and a stove, quite incapable of course of realizing that these various "instalments" totalled almost the weekly wage and left little for such trifles as food and clothing. Had more agents come to the house they would have promised more instalments.

The abject poverty of the feeble-minded is beyond description and is irremediable.

PUBLIC HEALTH PROBLEMS.

Infant Mortality.	Alcoholism.
Contagious Disease.	Specific Disease.
Tuberculosis.	Housing.

Miss Mary Dendy and other eminent authorities on the feeble-minded have drawn attention to the enormous infant mortality among the large families of the feeble-minded. It is no infrequent sight to see in the infants' homes and industrial refuges for women that the matron has had to take away her nameless infant from a feeble-minded mother, because she cannot be trusted for an instant to take care of the poor, poor baby, who should never have been born. Place it in her arms and even the mother's instinct fails. She may idly let it fall from her arms, or from her lap, and view its destruction with the terrible complacency of the ament. When we remember that the infant mortality rate is declared by the greatest living authority, Dr. Arthur Newsholme, to be the most sensitive index to the sanitary condition of any community, and that motherhood is the highest and the noblest and the most skilled of all occupations, we may well hang our heads in shame that we have not kept it sacred, but allowed its holy duties to be profaned by such sacrilege as this.

Do you seek a focus of contagious disease Are you wondering where the "carriers" are? Have you a register of the feeble-minded of the city in the office of the Medical Officer of Health? You will seldom miss your mark if you begin there.

Have you ever tried to care for a tuberculous patient who was feeble-minded? It can hardly be done—even in an institution. It takes intelligence to keep well, and more intelligence to recover from sickness. The feeble-minded help to cause and complicate this great problem, too. This very day a feeble-minded woman has been sent back from a sanatorium to our Women's Reformatory. They have done their best for nearly a year with her, but they now say they cannot take care of her. What does that mean in the community? It means that this is one reason why we progress slowly in the battle with the White Plague.

Alcoholism, as is now well known, is another effect of feeblemindedness. This temptation, too, the feeble-minded are unable to resist. Dr. Branthwaite, Inspector of Homes for Chronic Inebriates, found over 60 per cent. of the inmates of these homes feeble-minded.

As for Specific Disease, it is possible that more people are contaminated with specific disease through a feeble-minded woman, who has one or other, or both of these diseases, than in any other way whatever. There must be many people here who have proved this in the course of their investigations, and this problem must be faced. The conspiracy of silence is broken. New York and other great cities are taking steps to treat this as a public health problem. The report of the British Royal Commission on Venereal Disease, just published, has been so influential and so much in accord with public opinion that on April 14th, 1916, Mr. Walter Long, of the Local Government Board, told a deputation that His Majesty's Government would give to all local Health Boards a money grant equal to 75 per cent. of what they pay for the diagnosis and treatment of venereal disease. The care of the feeble-minded would save the other 25 per cent.

The problem of housing in new nations or younger nations is in the nation's own hands—a great opportunity. But where the feeble-minded go they make slums round them. Have you ever, anywhere, and under any circumstances, in a house where normal people live, smelt anything to compare with the indescribable, compressed complex horrible odor of the air in one of these abodes of the feeble-minded? They complicate the housing problem and they cannot help making slums.

Problems of Public Safety.

As for problems of public safety—in other words—crimes, an eminent English authority, Dr. Charles Goring, Medical Superintendent of His Majesty's Prison in Parkhurst, points out that though there are only .46 per cent.

of mental defectives in the general population, there are these percentages of mental defectives among those convicted of:

	Per cent.
Wilful damage, including maiming of animals	22.2
Arson	16.7
Rape (child)	15.8
Robbery with violence	15.6
Unnatural (sexual) offences	14.3
Blackmail	14.3
Fraud	12.8
Stealing (and poaching)	11.2
Burglary	10.0
Murder and murderous intent	9.5
Rape (adult)	6.7
Receiving	5.1
Manslaughter	5.0
Coining	3.3
Wounding, intent to wound, striking superior officer	2.9
Embezzlement, forgery, fraudulence as trustee, bigamy, performing illegal surgical operation	0.0

What is the relation of the problem of the feeble-minded to these social problems? Cause and effect once more. Dr. Fernald says, and we all will agree, that every feeble-minded person is a potential criminal. On the whole, at least from 10 to 20 per cent of all the inmates of penal institutions are feeble-minded.

Public Morality Problems.

And as for public morality, here is a valuable summary of recent authoritative statistics:

The Social Evil.

This problem is as old as human history, and still unsolved. Why?

No one denies that those who are arrested are not the clever ones, not the sharpest and best able to escape at the expense of their companions, but there are many women in immoral houses who are victims, and there are few modern investigators who do not take account of this and of the fact that a large proportion of the victims of the White Slave Traffic are mentally defective. Dr. W. F. Snow has published a study in which he tabulates the results of recent investigations.

	Number Prostitutes Examined.	Per cent. Aments.
State Board of Charities and Correction, Richmond, Va.	120	83.3
Chicago Morals Court	639	62.0
Illinois Training School for Girls	104	97.0
Massachusetts Vice Commission	300	51.0
Massachusetts State Woman's Reformatory	243	49.0
New York State Reformatory for Women	193	29.8
Bureau of Social Hygiene	100	29.0
Total	1,825	

Mental defectives with little sense of decency, with no control of their passions, with no appreciation of the sacredness of the person and the higher references of life, become a centre of evil in the community, and inevitably lower the moral tone.

Problems of Public Duty.

We have sat down at the Banquet of Life. Shall we rise and attempt to escape without paying the reckoning? Having received life and liberty, and being free to pursue our happiness, are we to be content to pass into oblivion without doing anything to repay to the

generation soon to succeed ours, what we ourselves received at the hands of the generation that preceded ours? That generation bore us, nursed us, taught us to walk and think, and work and pray. They made us their heirs. Have we no heritage to pass on to our heirs? Life is a trust. We are only life tenants of the national heritage. It is not ours to lessen or destroy—it is ours to increase and enjoy. So we must consider all these social problems in the light of public duty. We must not

> "Promise, pause, prepare, postpone,
> And end by letting things alone."

The very least we can do for society—the society that gave us our opportunity, and made us what we are—is to leave behind us other trained hands to take hold of the wheel when our voyage is done. Hands that we have helped to train and that we have sacrificed somewhat for. "There is no wealth but life. That country is the richest that nourishes the greatest number of noble and happy human beings." (Ruskin).

It is also our duty to have a care of that which is not so much the heritage of the nation to be as it is the very nation to be itself. "Our duty to our neighbor must now be held to include our duty to posterity." It is a great public duty to see that as the nation rests upon the home for its foundation, so those who never can make or help to make a home are not permitted because of our selfish hearts and slack hands, to debase the national life and to degrade the glory of the national character. Knowing what we know now about the feebleminded, it is a sin to permit them to raise up children in their likeness, as we now do. We are bound to make our knowledge tell on the national policy. "I have set watchmen upon thy wall, O Zion," said the prophet, "which shall never hold their peace day nor night." We have but to follow their example, and look for the day.

"We stand on the threshold of an age which is to herald the recognition of the mother and her child, to give public health work that human touch it has hitherto lacked, and to modify those glaring inequalities in social life and condition which are destructive alike of infancy and the ideals of Christian citizenship."

This is partly a question of education—it is a question of remedying the deficiencies of our modern educational systems, which have not reckoned with the feebleminded, and there never was a time when it was more plain that to economize in education is to economize in the foundation stones of the temple of national freedom and national greatness.

American National Conference of Charities and Correction. Annual meeting, Indianapolis, May 10th, 1916.

BOOK REVIEW.

Mentally Defective Children. By G. E. SHUTTLEWORTH, B.A., M.D., and W. A. POTTS, M.A., M.D. London: H. K. Lewis & Co., Ltd., 136 Gower Street. Philadelphia: P. Blakiston's Son & Co. Fourth Edition, 1916.

The third edition of this valuable book is exhausted and the new edition has been thoroughly revised and carefully brought up to date.

Since the issue of the third edition "The Mental Deficiency Acts" for England, Wales and Scotland have been passed, and other changes have necessitated the rewriting of many parts of the book.

Chapter VI., dealing with the mental disturbances of childhood, has been added, and we hope that in future editions more attention will be paid to this subject

The illustrations have been increased in number and have been better arranged.

A French translation of this book has been published, and permission to translate it into Japanese has recently been requested.

The book has a great many excellent features. The bibliography, the index, the list of reports all have their own value, and mental tests are also given.

The chapters on Treatment and Educational Training are most interesting, and the book may be recommended to those interested in the subject not only on account of the thorough, accurate and scientific information contained in it, but because of its suitability for the public as well as for teachers and the medical profession.

Dr. Shuttleworth and Dr. Potts have again laid those interested in this subject under a debt of gratitude.

ANNUAL EXAMINATION OF NURSES AT ONTARIO HOSPITALS FOR THE INSANE.

The successful nurses at the examinations held at the different hospitals in the month of May, 1916, are as follows:

Brockville Training School.

First Year.—Alice McCaffrey, Christina Colquhoun, Lena Lyons, Annie Frame, Anna Lally, Onadell Belway, Helena Hewitt, Kathleen Frame, Lottie Storey, Kathleen Hughes, Ada Hughes, Winnifred Daughan, Florence Mahoney, Lou Goldthorpe.

Second Year.—Hazel Farmsworth, Nellie Ritchie.

Third Year.—Margaret Gavin, Elsie Lackey, Marie Burns, Josephine Bedard, Lulu Sunderland, Reta Hanna.

Kingston Training School.

First Year.—Loretta McConnell, Loretta Whalen, Ida Barclay, Annie Coutoure, Clio Coutoure, Ruth Luby, Jennie Foster, Pauline McConnell, Marie Murphy, Anna O'Neill, Mary Luby, Gertrude Haffie.

Second Year.—Alberta Snider, Evelyn Kiell, Mabel Trousdale, Louisa Dwyer, Annie Neilson, Eileen Trousdale.

Third Year.—Phyllis Murphy, Bessie Greanfield, Elma Kennedy, Margaret Scott.

Mimico Training School.

First Year.—Emma Livingstone, Mae Herbert, Kathleen Hanna, Ruby E. Twitchett, Pearl Davis, Margaret Collins, Stella Artingstall, Alice M. Colston, Florence E. Johns, Georgina Carling.

Second Year.—Elizabeth Doverty, Clara Tipler, Mary McKenzie, Wilhemina Krause, Eugenie Russell, Sadie Calam.

Third Year.—Jane Ronald.

Toronto Training School.

First Year.—Annie B. Gordon, Emily M. Holledge, Leila T. Hall, Gladys Hooper, Edith James, Florence Jones, May Knott, Sadie Knox, Mary Meldrum, Kathleen McCoy, Agnes I. McLennan, Cecelia McKenna, Christina McGillivray, Nellie Watson, Florence Watson.

Second Year.—Ellen A. Franklin, Elizabeth M. Hendry, Helena Hancock, Margaret E. Lawless, Maggie Paterson, Ada R. Scott, Mary Thomson, Margaret Wilson.

Third Year.—Elsie Austin, Mary Adshead, Julia Broderick, Alice Deer, Louisa M. Henry, Agnes Keenan, Charlotte McDonald, Amy E. Peake, Pansy Paine, Janie Reilly, Elizabeth Sheehan, Laura Topping, Elizabeth W. Turner, Isabella Wylie, Jessie Whitelaw.

Hamilton Training School.

First Year.—Mary Botsford, Florence E. Collyer, Margaret A. Collyer, Zella L. Coon, Cathleen Davies, Marie Fraser, Amy Hill, Ethel Hopwood, Nellie Pamplin, Margaret Martin, Frances McKenna, Marguerite C. Mooney, Ina N. Rutherford, Olive Rutherford, Elizabeth Wilson, Florence M. Wilson.

Second Year.—Sarah Black, Elsie Carr, Lillian M. Fish, Clarice E. Hibbert, Lizzie Maire, Edith Ponting, Mary Thomas, Etta L. Tully.

Third Year.—Alberta Cave, Sadie E. Denvir, Kathleen Douglas, Lucy Holgate, Ethel P. M. Jillings, Laveania M. Kelly, Anna Letta, Annie Maynard, Mary Whittingham.

London Training School.

First Year.—Mary Allen, Mary Davis, Mabel Conley, Evelyn E. Evans, Josie Howick, Kate O'Keefe, Florence Hughes, Mary Preston, Helen Temple, Florence Bishop.

Second Year.—Eva Bonnell, Dora Leonard, Jean Mason.

Printed by
WILLIAM BRIGGS
Queen and John Streets
TORONTO